

Letters

Website: bmj.com
Email: letters@bmj.com

Fallout from the Shipman case

Deaths should be investigated more plainly and effectively

EDITOR—O'Neill's editorial and the news article by Dyer, which both arose from the Shipman case, raise several points that merit further consideration.^{1,2}

The fact that a central registry of doctors' prescribing habits is geared to financial rather than good practice principles perhaps reflects the current fiscal climate. Concern about death certification and coroners dates back to the Brodrick committee.³ I wonder what was entered on the death certificates of Shipman's patients, how carefully the certificates were scrutinised by the registrar of births, deaths, and marriages, and what was the degree of training and expertise of those scrutinising them.

Australian experience mirrors that of the United Kingdom, with inaccuracies in death certificates. Surely, however, characterising the immediate cause of death of valued citizens, irrespective of their age or sex, can never be meddlesome. Inaccuracy in documenting any aspect of medical practice should not be readily accepted.

Advice to authors

We prefer to receive all responses electronically, sent either directly to our website or to the editorial office as email or on a disk. Processing your letter will be delayed unless it arrives in an electronic form.

We are now posting all direct submissions to our website within 24 hours of receipt and our intention is to post all other electronic submissions there as well. All responses will be eligible for publication in the paper journal.

Responses should be under 400 words and relate to articles published in the preceding month. They should include ≤ 5 references, in the Vancouver style, including one to the BMJ article to which they relate. We welcome illustrations.

Please supply each author's current appointment and full address, and a phone or fax number or email address for the corresponding author. We ask authors to declare any competing interest. Please send a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.

bmj.com
letters@bmj.com

The English coronial system was adopted by many former colonies but has largely tended to diverge from English practice. In New South Wales the coroner's act requires any person to report any death or suspected death within a defined category to a member of the police or a coroner. This is a general duty and not one peculiar to the medical or nursing professions. Some 6000 of around 50 000 deaths are so reported each year. Generally, every coronial death will have a full necropsy, 4500 by a forensic pathologist.

Pathologists conducting necropsies should always have a high index of suspicion. Although interpreting opiate concentrations in fresh cadavers is difficult and made much worse by decomposition, postmortem drug screening reveals the presence of most therapeutic drugs and many poisons and is both rapid and inexpensive using blood and urine samples.

In this brave new fiscal world the cost effectiveness of necropsy and analytical process may be questioned, but probably not by the relatives of Shipman's victims. The more comprehensive the necropsy the more difficult it is to hide secret homicide. Although no system can guarantee that the subtle murderer will be found out, a civilised society should not be seen to be too readily removing obstacles from such a person's path.

All legal systems surrounding the reporting, recording, and investigation of death have their weaknesses. Perhaps all death certificates should be inspected by forensically aware medical practitioners who are totally protected from outside influences and are able to review all deaths when and wherever they occur. With computer back up and a higher necropsy rate this reform might go some way to discouraging the Shipmans of this world and show that the state has a vested interest in protecting the lives of its citizens by investigating their death in a more forthright and effective manner.

J M N Hilton *director*
New South Wales Institute of Forensic Medicine,
Sydney, Australia
acamer@iofm.cs.nsw.gov.au

1 O'Neill B. Doctor as murderer. *BMJ* 2000;320:329-30. (5 February.)

2 Dyer C. Tighter control of GPs to follow doctor's murder conviction. *BMJ* 2000;320:331. (5 February.)

3 Home Office. *Report of the committee on death certification and coroners*. London: HMSO, 1971. (Cmnd 4810.)

Existing safeguards against secret homicide are defective and have been weakened

EDITOR—The minister of health reacted to the Shipman case by assuring the public that more controls will be imposed on the medical profession.¹ But the Home Office and not the Ministry of Health is responsible for the law relating to coroners, death certification, disposal of dead bodies (including cremation), and, in the Shipman case, the control of drugs. The law collectively provides the main safeguards against the concealment of secret homicide. The Home Office has not only ignored the many warnings from the BMA about the defects of the existing safeguards but also attempted repeatedly to relax them.

Unfortunately the Home Office has been aided and abetted by the Brodrick committee, the only body ever set up by government to consider the safeguards as a whole and whose report can only be described as disastrous. In paragraph 4.37 it states: "Our general conclusions are that the risk of secret homicide occurring and remaining undiscovered as a direct consequence of current law on the certification of death has been much exaggerated, and that it has not been a significant danger at any time during the past 50 years."²

The BMA pointed out to the committee, as did representatives from among the funeral directors, that morticians are in the best position to recognise unsuspected cases of homicide but that they were most reluctant to report their suspicions to the coroner without a statutory obligation when a certificate of death from natural causes had already been given. The committee's response in paragraph 12.32 was: "We do not think that they could or should be singled out for the responsibility as they proposed." On cremation, which practically destroys all evidence of violence, the committee said in paragraph 27.34: "We see no need for the retention of any of the existing cremation forms and certificates or for the office of medical referee and we recommend that they be abolished."

Although some serial murderers have succeeded in getting the deaths of their victims certified and disposed of as natural deaths since the committee met, the Home Office has continued to oppose any strengthening of the existing safeguards and has, in the case of cremation, tried to weaken them. The danger, of course, is that the medical profession, having regard to the views expressed by the Home Office and the departmental committee, can hardly

be expected to assign high priority to its responsibilities under the existing safeguards.

John Havard *secretary, Commonwealth Medical Association*
London N1 3DL

- 1 Dyer C. Tighter control of GPs to follow doctor's murder conviction. *BMJ* 2000;320:331. (5 February.)
- 2 Home Office. *Report of the committee on death certification and coroners*. London: HMSO, 1971. (Cmd 4810.)

A system is already in place, but the powers of medical referees in cremation must be made truly effective

EDITOR—Frankel et al are right to warn us of the dangers of inappropriate policy responses to the outcome of the Shipman trial.¹ As they have shown, the production of mortality league tables in general practice would be a wholly misconceived, expensive, and useless way of monitoring the situation.

The irony is that a system is already in place that with comparatively minor changes would allow individual audit to be conducted on three quarters of the deaths in the United Kingdom and could easily be extended to cover the rest. The reasons why this system failed so many of Shipman's patients are complex, but the medical profession must not be made the scapegoat for the failures of others. If the Home Office continues to refuse to discuss the essential changes necessary to regulations under the cremation acts proposed by the BMA, doctors are likely to conclude that no one is interested in the outcome and thus reduce the process to a bureaucratic chore to be completed as quickly as possible and with the minimum inconvenience to all those concerned. We as doctors must plead guilty that we have not maintained the necessary suspicion that some of our colleagues will be guilty of serious errors, and worse, from time to time.

A Nelsonian blind eye to such possibilities has no place in modern medical practice. The lack of clear guidance on the doctor's responsibilities in completing the confirmatory certificate and its ambiguous wording do not help matters. Medical referees told the BMA that they want more training and more uniform standards² rather than more money, whatever their detractors claim.³ Will their needs be considered by the General Medical Council in its present rush to measure individual performance at regular intervals?

Will the existing powers of crematorium referees be made effective in fact as well as theory? The matter is now the subject of the inevitable public inquiry. This will delay the much needed reforms as the various parties dispute their respective responsibilities and the subject fades from public memory. A previous attempt at reform took seven years to consider the issues, and none of its key recommendations was ever implemented.⁴ We owe it, both to Shipman's patients and to our own, to make sure that it does not happen again.

Stuart Horner *professor in medical ethics*
Centre for Professional Ethics, University of Central Lancashire, Preston PR1 2HE
stuart.horner@tesco.net

- 1 Frankel S, Sterne J, Davey Smith G. Mortality variations as a measure of general practice performance: implications of the Shipman case. *BMJ* 2000;320:489. (19 February.)
- 2 Horner S. Crisis in cremation. *BMJ* 1998;317:485-6.
- 3 Arber RN. Crisis in cremation. *BMJ* 1999;318:812.
- 4 Home Office. *Report of the committee on death certification and coroners*. London: HMSO, 1971. (Cmd 4810.)

Death registers in general practice would be a means of preventing malpractice and murder

EDITOR—Shipman has shamed the medical profession.¹ We as doctors should scrutinise existing safeguards and create systems to save lives and prevent another such tragedy. We must seek tested approaches and not rush into ineffective schemes.

The Newcastle audit of death in general practice project, funded by the Department of Health in 1991, is worth revisiting. Its results show that general practitioners might not learn about the cause of death of their (or their partners') patients because hospital doctors sign most death certificates and the feedback loop may not be closed.²

Death certificates do not record a person's general practice or general practitioner. A telephone survey of 15% of health authorities in the early 1990s found none with experience of producing practice specific mortality lists or figures. By using details on the death certificate and the health authority's population register, which names the general practitioner, a death register for each general practice in Newcastle upon Tyne was created. This register was produced at a weekly cost of three hours of secretarial time for a population of about 280 000.

Practice specific questions about death rates could potentially be answered using this register, but producing these data was judged to be ineffective because of the small number of deaths. In the wake of Shipman such rates may be calculated but will be difficult to interpret as data on rare events in small populations. The register proved valuable for administrative purposes and for auditing the quality of clinical care, including the systematic, critical scrutiny of deaths by the practice multidisciplinary team using the critical incident method.³ The insights led to beneficial changes in practice administrative and clinical policy.^{2,4}

To evaluate care given by single handed practitioners we will need to rely on external observers or other members of the primary care team. The project showed that an external person could facilitate discussions.^{2,4}

General practices wanted necropsy reports, but there was no system or funding to make them available, and there was a lack of understanding of the importance of making such reports more widely available.⁵ The

Newcastle death project was not designed to prevent murder in general practice, but its implementation nationally would deter malpractice, help monitor standards of practice, and improve quality of care. Leadership by the nation's departments of health is required. A national project would be a fitting memorial to Shipman's victims.

Raj Bhopal *Bruce and John Usher professor of public health*
Department of Public Health Sciences,
Medical School, Edinburgh EH8 9AG

- 1 O'Neill B. Doctor as murderer. *BMJ* 2000;320:329-30. (5 February.)
- 2 Berlin A, Bhopal RS, Spencer JA, van Zwanenberg TD. Creating a death register for general practice. *Br J Gen Pract* 1993;43:70-2.
- 3 Berlin A, Spencer JA, Bhopal RS, van Zwanenberg TD. Audit of deaths in general practice: pilot study of the critical incident technique. *Quality in Health Care* 1992;1:231-5.
- 4 Stacy R, Robinson L, Bhopal RS, Spencer J. Evaluation of death registers in general practice. *Br J Gen Pract* 1998;48:1739-41.
- 5 Berlin A, Wagstaff R, Bhopal RS, Spencer J. Postmortem examinations: general practitioners' knowledge, behaviour, and attitudes. *BMJ* 1994;308:1080-1.

Publication of mortality data for individual GPs will keep focus on potential to do harm

EDITOR—I have been keeping records of the deaths of patients registered with me since 1989 and was pleased to find that they are broadly in line with the figures quoted by O'Neill in his editorial (table).¹

I practise from a modern health centre in a partnership of four doctors and almost 7000 patients. We have personal lists within this system. There has not been a death on our premises since we moved in 1988, and I can recall being with only two patients at the moment of death since starting in practice in 1985.

Shipman was a singlehanded practitioner when he was abusing pethidine and again when working in Hale, Greater Manchester. Solo practice may have advantages, but the chances of professional drift, isolation, and the lack of peer approval may be counterproductive and contribute to extreme behaviour in certain cases.

In Tower Hamlets general practitioners, pathologists, and the coroner have large workloads. Elderly patients, in particular, are at considerable risk in such systems, but for a general practitioner to be asked by the coroner's officer to supply the cause of death even if it is more than two weeks since he or she last saw the patient is not unusual. It says a lot for the integrity of all concerned that, so far as we know, the system is abused so rarely.

Since the Shipman verdict I have gained from the simple knowledge of my figures, but had you asked the question of me last year I would have been unable to give details

Numbers of deaths by place of death among patients registered with Dr J Hardy, Bethnal Green Health Centre, London, 1990-9

Place of death	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Home	2	5	11	2	4	6	7	5	6	2
Hospital or hospice	12	16	22	12	9	16	12	15	15	10
Elsewhere	0	0	0	1	0	0	0	0	0	0
Total	14	21	33	15	13	21	19	20	21	12

and would certainly have had no knowledge of the figures of my partners or other practitioners in the borough.

Perhaps this does not matter, but some people might have had suspicions about Shipman. Unless they had had the time, energy, and motivation to rise above the pressures of a working life, those suspicions would have faded with the rest of their thoughts at the end of a busy day.

I argue for a system that enables practitioners or other professionals to voice concerns informally and in strict confidence. Such a system must be easy to use and act as a sounding board for even the most speculative of conjectures.

The publication of individual figures may be a little crude, but it will help to focus our gaze on the chilling reality of our theoretical potential to do great harm.

Jim Hardy *general practitioner*
Bethnal Green Health Centre, London E2 6II

1 O'Neill B. Doctor as murderer. *BMJ* 2000;320:329-30. (5 February.)

Group practice safeguards patients

EDITOR—I was shocked by O'Neill's apparent complacency in his editorial published after Shipman's conviction.¹ Obviously, no system of death registration in the world is going to prevent a dedicated murderer from going about his or her business. However, as a partner in a group practice I can say with complete confidence that I would notice that something strange was wrong if five of my partner's patients had died in the surgery and there had been no attempts at cardiopulmonary resuscitation or calling an ambulance. Partners have regular meetings; they discuss patients and will notice if large numbers of otherwise fit patients are dying. They are also likely to notice if records are being tampered with.

Singlehanded general practice is defended as good because of the continuity of care provided and because patients say they like it. Absolute continuity of care has gone from modern general practice—how many general practitioners in singlehanded practice do all their own on call work and never take a holiday? Personal lists within a group practice can deliver an equivalent degree of continuity of care. Patients are not always good judges of what makes good general practice—Shipman had a large list size and was well thought of.

I think the day of singlehanded general practice is over. Group practice provides safeguards for the patient as well as a stimulating working environment.

Kath Checkland *general practitioner*
Stockport SK6 5PQ
kath.checkland@dial.pipex.com

1 O'Neill B. Doctor as murderer. *BMJ* 2000;320:329-30. (5 February.)

Requirement that general practice records be on government forms for legal reasons needs to be updated

EDITOR—Until recently general practitioners were wary of using only electronic

records because of the risk of the record not being able to be allowed in court in event of a dispute. Regulation 635 of the 1992 terms and conditions of service for general practitioners states that records have to be kept on the forms provided by the secretary of state.

This part of the contract for general practitioners is now outdated and should be urgently replaced. As electronic records have become more sophisticated, worries about acceptance of records in court have become less of a problem. All computer systems in general practice that are compliant with the latest requirements for accreditation (RFA4) have an audit trail built into them. Thus the person who altered a record and when he or she did so can be recorded. Although such audit trails are now an integral part of the software, even systems that did not have them specifically included have been used in court. Two cases are important:

- In 1995 a doctor in South Wales was found guilty of altering patient records on his computer and jailed. He had accidentally prescribed a β blocker to a patient with a history of asthma, resulting in the patient's death. He tried to remove electronic references to asthma treatment on his computer system, but the alterations were detected and he was convicted.

- Shipman also altered the computer records of his patients after their deaths to fit with the cause of death that he had put on the death certificate.¹ The way that the Microdoc system that he used recorded the information enabled the prosecution to demonstrate that some records had been added months after they were meant to have been. Their position in the database was incompatible with the date attached to them.

These two cases and current audit trails should enable doctors, or lawyers acting on behalf of litigious patients, to use electronic medical records from British general practice in future court cases. The requirements of the terms of service to use paper records should thus be abandoned.

Trefor Roscoe *informatics tutor, North Trent*
Health Centre, Sheffield S20 1BJ
Troscoe@sheffield.ac.uk

1 O'Neill B. Doctor as murderer. *BMJ* 2000;320:329-30. (5 February.)

Having any social elite has dangers, but beware the pitfalls in regulating professions

EDITOR—The Shipman case will be discussed for years¹ and highlights how any profession can become too powerful with insufficient checks on the actions of its members. The main legal controls of the Medical Act 1858—a register of practitioners and the formation of the General Medical Council—still seem to be insufficient in preventing a minority from abusing their status.

Some will doubtless have seen this sad case as an accident waiting to happen and the medical profession as an overprivileged, elite class, answerable only to itself, out of touch with its patients, and thus potentially

corrupt. Doubtless, politicians and lawyers will now work with great energy to change this.

There are historical precedents. The arrogant, reckless, and flamboyant lifestyle of the 18th century French aristocracy, compared with that of their peasant subjects, was probably the main cause of the revolution which saw the aristocracy bloodily swept from power. Similar impulses drove the Bolshevik revolution of 1917. These are good examples of the tragic consequences of the unbridled power and privilege of a ruling class, answerable to no one.

In this sense, the Shipman case exemplifies how any profession that becomes overprivileged, protective chiefly of its own interests, answerable to few, and the sole arbiter of its own affairs must be subject to similar temptations. All members have the potential to do what Shipman did, or to abuse the power invested in them by patients, with apparently only feeble systems of prevention. Shipman also concealed his actions from fellow professionals. Naturally, the introduction of great change is now anticipated.

However, how many new checks are needed? The Shipman affair will inevitably inspire tighter regulation of doctors, but hopefully not ones as excessive as the checks, balances, and inspections endured by teachers, who endure oppressive scrutiny every working day. As a profession, teaching has been robbed of much control over its own affairs. Will such excess scrutiny now be visited on the medical profession?

While professions should be free to control their own affairs, and be subject to scrutiny by the state too, how can that be done discreetly and effectively? What is only a narrow band of acceptable scrutiny can lapse into dangerous sloppiness on one side or restrictive oppression on the other. Doctors have endured little scrutiny, but teachers an excess. Setting in place draconian inspection systems would restrict the freedom of the profession and should be tempered by being both benign and discreet.

Peter Morrell *honorary research associate, history of medicine*
Department of Sociology, Staffordshire University,
Stoke-on-Trent ST4 2DE

1 O'Neill B. Doctor as murderer. *BMJ* 200;320:329-30. (5 February.)

Hasty political decision on serious professional misconduct may restrict GMC's regulatory abilities

EDITOR—Reports of the government's intention to increase the penalty for a proved charge of serious professional misconduct have received the support of the president of the General Medical Council.¹ In the light of the Shipman case² and others I am sure these proposals will also gain public approval. I am concerned about the proposed minimum tariff of five years before an application for restitution can be made and that a life ban should become the usual penalty.

Medical practitioners may be struck off for several reasons, and I am not convinced that all of them merit a life ban: this should surely be just one option available to the Professional Conduct Committee. Is this not the reason that the committee considers the facts of any case and only then imposes a sentence?

As the committee acts as both judge and jury, I worry that members will find it more difficult to divorce their consideration of the merits of the arguments from the penalty. This is one of the strongest arguments for juries not having sentencing power. I welcome any change that will safeguard patients and restore their confidence, but a hasty political decision may actually restrict the GMC's abilities to regulate the profession rather than improve them.

Andrew J Hartle *visiting associate in anesthesiology*
Duke University Medical Center, Durham, NC
27707, USA
hart005@mc.duke.edu

1 Anonymous. Life bans for danger doctors. *BBC News Online* 2000 Mar 24 (13:10 GMT).

2 Dyer C. Tighter control of GPs to follow doctor's murder conviction. *BMJ* 2000;320:331. (5 February.)

Shipman's family should not have to face penury as well as everything else

EDITOR—I was shocked to hear that the secretary for health, Alan Milburn, was to remove Shipman's right to a pension.

He will not need it, but what of his family? He has a wife and a son of 17 who will now have to face the problems of their relationship to Shipman and, it seems, the removal of their source of income, although they are innocent of any crime.

Shipman paid towards his pension. It is an act of theft to refuse reimbursement in some way. I hope that the BMA will not let Primrose Shipman and her children suffer penury as well as social ostracism.

Helen Clark *retired casualty officer*
Street, Somerset BA16 0HB

Study on environmental hazards is flawed

EDITOR—Studies examining the impact on health of environmental hazards pose particular challenges to reaching judgments about cause and effect. We have several concerns about McCarron et al's study of the health of people living in an area contaminated by chromium waste.¹

Firstly, the authors justify their use of the SF-36 validated quality of life questionnaire only by saying that it is a validated quality of life questionnaire. The SF-36 was "developed as an outcome measure to detect changes in health status that might be expected to occur as a result of health-service use within a relatively short period of time,"² and its use in a study that aims to measure self reported health in a population exposed to an environmental hazard is questionable. A more suitable approach would be to measure self reported health status, chronic illness, and a wide range of symptoms. A number of

comparisons could then be made between study and control groups; with published data; and, in the study group, between symptoms which are and are not plausibly associated with exposure.³

Secondly, separating a "true" biological effect from reporting that is increased because of "awareness bias" is problematic in communities that are aware of their exposure. McCarron et al removed those people who believed that the hazard had an adverse effect on health—a quarter of their study sample. In two studies investigating the impact of industrial pollution on the health of surrounding populations, we found that in both the study and control groups those subjects who worried about industrial pollution reported more illness, making it difficult to assess the direction of causality.⁴ Relying on data from only those who believe that the hazard has no effect produces a biased picture. We do not advocate an unquestioning approach to personal accounts of illness, but we suggest additional analysis of other datasets—for example, general practitioner records, hospital data, and exposure measurements. If the aim is to remove uncertainty about awareness bias and improve methodological rigour then self reported data should not be used alone.⁴

Thirdly, McCarron et al found that most respondents preferred improvements to local amenities over chromium remediation. In our view, this does not imply acceptance of the hazard: rather, it supports recent findings on "pollution injustice."⁵ Poorer communities are more likely to be exposed to pollution than affluent communities. Forcing a choice between improved amenities or a clean up is unjust. Wherever possible, both actions are required.

Suzanne Moffatt *lecturer in social epidemiology*
Department of Epidemiology and Public Health,
School of Health Sciences, University of Newcastle,
Newcastle upon Tyne NE2 4HH
s.m.moffatt@ncl.ac.uk

Raj Bhopal *Bruce and John Usher professor of public health*
Department of Public Health Sciences, Medical
School, Edinburgh EH8 9AG

1 McCarron P, Harvey I, Brogan R, Peters TJ. Self reported health of people in an area contaminated by chromium waste: interview study. *BMJ* 2000;320:11-5. (1 January.)

2 Bowling A. *Measuring health. A review of quality of life measurement scales.* Milton Keynes: Open University Press, 1992.

3 Bhopal RS, Moffatt S, Pless-Mulloli T, Phillimore P, Foy C, Dunn C, et al. Does living near a constellation of steel and petrochemical industries impair health? *Occup Environ Med* 1998;55:812-22.

4 Moffatt S, Pless-Mulloli T, Bhopal R, Foy C, Phillimore P. An exploration of awareness bias in two environmental epidemiology studies. *Epidemiology* (in press).

5 Friends of the Earth. *Poisoning the poor: pollution linked to inequalities.* London: Friends of the Earth, 1999. <http://www.foe.co.uk/pollution-injustice> (accessed 3 Apr 2000).

Has the sun protection factor had its day?

Information on sunscreens should warn against excessive sun exposure

EDITOR—We approve of Diffey's proposition to clarify the information about sunscreens by abandoning numerical labelling and

instead using measures focusing more on protection.¹ In most fair skinned populations, sunscreens are used during recreational sun exposure, and quantities applied to the skin are only about one quarter of those used to measure the sun protection factor,² even when sunscreens are given away free.³ It is unlikely that the quantity of sunscreen applied would increase substantially. Therefore, information on characteristics of sunscreen products should reflect the conditions in which most people will use them. Hence, ideally, the sun protection factor (or any other variable related to the properties of a sunscreen) should be measured using a thickness of sunscreen that agrees with actual use, for instance 0.5 mg/cm².

Diffey looks at sunscreens only in terms of sunburn, assuming that more generous application would decrease the occurrence of sunburn. Skin cancer also needs to be considered because a higher sun protection factor is often assumed to confer greater protection against skin cancer. However, suberythemal doses of ultraviolet radiation may be involved in biological events relevant for cutaneous melanoma or basal cell skin cancer.

A randomised trial in Australia showed that in cases of chronic exposure to the sun, daily use of sunscreen could decrease the incidence of both sunburn and squamous cell skin cancer (but not the incidence of basal cell skin cancer).^{4,5} The picture seems different in cases of recreational exposure to the sun, when the use of sunscreen does not seem to affect the occurrence of sunburn.^{2,3} A double blind randomised trial showed that use of higher sun protection factor sunscreens may relate to recreational sun exposure of longer duration.³ The longer exposure to the sun was unconscious—that is, the ability of sunscreens to delay sunburn supported people's intention to stay in the sun. These findings may partly explain why epidemiological studies found moderate increases in the risk of cutaneous melanoma and basal cell skin cancer associated with use of sunscreen. Where there is recreational exposure to the sun without control of time spent in the sun, increasing quantities of sunscreen applied to the skin could further encourage exposure to the sun. Information given to sunseekers should warn them that use of sunscreen could inadvertently increase the duration of their exposure to the sun, especially if they use a high sun protection factor sunscreen product.

Philippe Autier *deputy director*
philippe.autier@ieo.it

Gianluca Severi *biostatistician*
Division of Epidemiology and Biostatistics,
European Institute of Oncology, Milan 20141, Italy

Jean-François Doré *research director*
Mathieu Boniol *research fellow*
Institut National de la Santé et de la Recherche
Médicale, Centre Léon Bérard, Lyons, France

1 Diffey B. Has the sun protection factor had its day? *BMJ* 2000;320:176-7. (15 January.)

2 Wulf H, Stender IM, Lock-Andersen J. Sunscreens used at the beach do not protect against erythema: a new definition of SPF is proposed. *Photodermatol Photoimmunol Photomed* 1997;13:129-32.

- 3 Autier P, Doré JF, Négrier S, Liénard D, Panizzon R, Lejeune FJ, et al. Sunscreen use and duration of sun exposure: a double blind randomized trial. *J Natl Cancer Inst* 1999;15:1304-9.
- 4 Green A, Williams G, Neale R, Hart V, Leslie D, Parsons P, et al. Daily sunscreen application and betacarotene supplementation in prevention of basal-cell and squamous-cell carcinomas of the skin: a randomised controlled trial. *Lancet* 1999;354:723-9.
- 5 Green A, Williams G, Neale R, Battistutta D. Betacarotene and sunscreen use: authors' reply. *Lancet* 1999;354:2164.

Sunscreen users need education in application technique

EDITOR—Diffey's article describes many of the problems associated with sunscreen use.¹ We have recently quantitatively assessed sunscreen application technique in photosensitive patients and shown that, even in this susceptible group, application is poor.² The overall median sunscreen thickness was 0.5 mg/cm², and key exposed sites such as the neck, temples, and ears were often missed completely. We showed that application technique can be improved by careful education, but even then the overall thickness of sunscreen rises to only 1 mg/cm², which is half the standard thickness used in testing sun protection factors.³ An application thickness of 1 mg/cm² is more appropriate for sunscreen testing; in addition, the public should be educated in appropriate sunscreen application methods.

Richard Azurdia *specialist registrar in dermatology*
Lesley Rhodes *consultant dermatologist*
 Department of Dermatology, Royal Liverpool
 University Hospital, Liverpool L7 8XP

- 1 Diffey B. Has the sun protection factor had its day? *BMJ* 2000;320:176-7, (15 January).
- 2 Azurdia RM, Pagliaro JA, Diffey BL, Rhodes LE. Sunscreen application by photosensitive patients is inadequate for protection. *Br J Dermatol* 1999;140:255-8.
- 3 Azurdia RM, Pagliaro JA, Rhodes LE. Sunscreen application technique in photosensitive patients: a quantitative assessment of the effect of education. *Photodermatol Photoimmunol Photomed* (in press).

Resuscitation decisions are often not documented early enough

EDITOR—I was not surprised to see that national guidelines on resuscitation decisions are being ignored.¹ I have worked in several hospitals on acute medical wards and often have seen fudged resuscitation decisions. I believe that the decision on resuscitation should, as with any treatment, be made by the patient first. If the patient is unable or too ill to make the decision it should be made in consultation with the nearest relatives available. The doctor's decision should be based on information from these two sources. In the rush of an acute admission there may not be time to gather this information, so an advance directive would be useful here.

Ideally all the information about a patient would be seen by the admitting consultant quickly and a resuscitation decision made quickly. Often, however, patients are admitted in the night or not seen until later on by the consultant. In these circumstances the medical senior house officer or registrar on call will have to make a decision about resuscitation, either (and preferably) before

or during a crash call. One of the key decisions to be made is the point at which to stop curative medicine and move to a palliative approach towards a dying patient. I suspect that this decision is frequently made but often not documented. Nurses in particular find this lack of clarity stressful. I also found this a stressful part of medicine.

I believe that an edict that all staff must resuscitate patients unless the consultant says otherwise is a recipe for futile, unwarranted, and unkind cardiac arrest calls for patients who are dying. These patients should be allowed to die in peace without lots of young doctors performing heroic but pointless cardiac resuscitation.

The medical wards of hospitals admit the oldest and sickest people in our community. I am certainly in favour of treating as many people as possible, but there comes a time for letting people go gently. I hope that if I am in that state my doctors (whatever grade they are) will have the courage to let me die peacefully, without useless resuscitation attempts.

Peter Davies *general practitioner principal*
 Alison Lea Medical Centre, East Kilbride G74 3BE
 mpdavies@strathaven22.freereserve.co.uk

- 1 Dobson R. Guidelines ignored on resuscitation decisions. *BMJ* 1999;319:536, (28 August).

The ethics of unlinked anonymous testing

Surveys provide essential information

EDITOR—Kessel et al voice concerns about the ethics of unlinked anonymous surveys and the proportion of the public who seem to be aware of such surveys.¹

The need to use the unlinked anonymous technique for surveillance of HIV was evident once it was appreciated that data from diagnostic testing, or obtained after explicit consent for unlinked testing, inevitably produced biased estimates of the prevalence of HIV.² The technique was adopted nationally in 1990 only after extensive consultation and general agreement that, with safeguards, it was legal and ethical.³ The surveys, which are overseen by the Department of Health, provide information that would otherwise not be available and is essential for planning and monitoring the control of the spread of HIV.⁴ They use blood that would eventually be discarded, which is left over after the completion of screening tests in genitourinary medicine and antenatal clinics. Before testing, every specimen is irreversibly unlinked from information that would identify the source individual. Hence infection status can never be traced back to a person. Essentially, the results represent groups in the community and not individuals.^{2,4}

Unlinked anonymous surveys in the United Kingdom started only after approval by local ethics committees, and refusals have been rare. Recently, these committees approved extension of the technique for surveillance of hepatitis A, B, and C.

Internationally, most countries have followed the United Nations Programme on AIDS and the World Health Organization's recommendation to use the technique; only two countries have decided against it.^{1,5}

A door to door survey found that only a third of the general public seemed to be aware of unlinked anonymous surveys, and that only a quarter disagreed with them.¹ People mainly become aware of the unlinked surveys when they attend participating clinics where patients are informed of the surveys by posters and leaflets. Patients who have concerns can discuss them with staff (an option not available in the door to door survey), and the proportion who finally object to their specimens being included is low.⁴ The percentage reported to be aware of the surveys is considerably higher than expected. It is higher for adults aged 25 to 54 years—those most likely to have attended a participating antenatal or genitourinary medicine clinic since the surveys began.¹

There is broad professional and public acceptance of the unlinked anonymous technique. In 1996 the chief medical officer's expert advisory group on AIDS reviewed the surveys and concluded again that they were ethical and should continue as they provide essential information on public health.⁴

Angus Nicoll *unlinked anonymous programme manager*
 anicoll@phls.nhs.uk

Noel Gill *consultant epidemiologist*
 PHLS Communicable Disease Surveillance Centre,
 London NW9 5EQ

David Goldberg *deputy director*
 Scottish Centre for Infection and Environmental
 Health, Glasgow G3 7LN

Catherine Peckham *professor of paediatric epidemiology*
 Institute of Child Health, University of London
 WC1N 1EH

- 1 Kessel A, Watts C, Weiss HA. Bad blood? Surveys of public's views on unlinked anonymous testing of blood for HIV and other diseases. *BMJ* 2000;320:90-1, (8 January).
- 2 Gill ON, Adler MW, Day NE. Monitoring the prevalence of HIV: foundations for a programme of unlinked anonymous testing in England and Wales. *BMJ* 1989;299:1295-8.
- 3 Heptonstall J, Gill ON. The legal and ethical basis for unlinked anonymous HIV testing. *CDR* 1989;48:3-6.
- 4 Nicoll A, Gill ON, Peckham CS, Ades AE, Parry J, Mortimer P, et al. The public health applications of unlinked anonymous seroprevalence monitoring for HIV in the United Kingdom—a review. *Int J Epidemiol* (in press).
- 5 Joint United Nations Programme on AIDS and the World Health Organization. *Report on the global HIV/AIDS epidemic June 1998*. Geneva: UNAIDS and WHO, 1998.

Testing need not stop

EDITOR—Kessel et al found that most (69%) respondents to their questions were not aware of the anonymous testing of blood for HIV and other diseases. They also found that 26% of respondents disagreed with the practice of testing.¹

The authors said that the policy should be reconsidered by the government in the interests of rebuilding confidence in the NHS. They also said that the ethical debate had changed because the HIV epidemic had not materialised. Have the ethical issues changed with time? In 1966 Henry Beecher wrote, "An experiment is ethical or not at its inception; it does not become ethical post hoc—ends do not justify means. There is no ethical distinction between ends and

means.^{1,2} For him neither the passage of time nor the results obtained changed the ethics of a study.

Is anonymous testing of blood for HIV and other diseases unethical? Does such a policy breach the four principles of biomedical ethics—namely, autonomy, non-maleficence, beneficence, and justice?³ It may be argued that anonymous testing breaches patient autonomy. However, the blood was taken, with consent in the first instance, for a particular purpose. It was used for that original purpose. There is no direct maleficence to the patient from its secondary use. There is no direct benefit either. The policy does not breach the principle of justice: anyone's blood might be used, as would have been the case even if there had been an HIV epidemic. The use of stored tissues for research remains controversial. At least one authority has argued that consent is not needed to use stored tissue, and by implication blood, from anonymous donors for research.⁴

The anonymous testing of blood for HIV and other diseases seems hardly comparable to the Tuskegee "bad blood" study. As only a minority of respondents disagreed with the policy, is there really a case to suggest that the testing should stop?

Bernard A Foëx *specialist registrar in accident and emergency*
Hope Hospital, Salford M6 8HD
bfoex@zen.co.uk

- 1 Kessel A, Watts C, Weiss HA. Bad blood? Survey of public's views on unlinked anonymous testing of blood for HIV and other diseases. *BMJ* 2000;320:90-1. (8 January.)
- 2 Beecher H. Ethics and clinical research. *N Engl J Med* 1966;274:1354-60.
- 3 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309:184-8.
- 4 Doyal L. Journals should not publish research to which patients have not given fully informed consent—with three exceptions. *BMJ* 1997;314:1107-11.

Author's reply

EDITOR—As well as explaining how unlinked anonymous testing is done, Nicoll et al reiterate that the results of the HIV seroprevalence surveys are of value to public health and that the methodology has been widely approved. None of this is contested in the original paper.¹ Nicoll et al also point out that refusals have been rare, but this tells us only about those people who are aware of the testing. The true number of objections may be much higher.

There is clearly a need to widen the debate. Important questions remain. Under what conditions is it acceptable not to let people (explicitly) know what is happening with their tissue samples? Does the ethical debate change as circumstances change? What are the best ways to engage the public in research and development and what are the consequences of not doing so? What are the best means of improving trust in the NHS? We have argued for a stronger emphasis on education and a need for further research. In time this may encourage embracing of some of these important issues.

Foëx makes a number of misplaced claims. Firstly, the ethical validity of the surveys at their inception is not questioned, only the validity now. The original moral

evaluation does not change with what we have learned subsequently, but undoubtedly the ethical debate shifts with time. Foëx adds that there is no moral distinction between ends and means—a statement that will sound strange to utilitarians or Kantians.¹

Next, Foëx's statement that there is no direct maleficence from unlinked anonymous testing of blood takes a narrow view of harm. After all, patients may feel psychologically harmed from blood being used without their agreement, and lack of openness may (indirectly) damage relationships between patients and healthcare workers and adversely affect trust in organisations such as the NHS.² The simplistic "four principles" approach of biomedical ethics has been extensively criticised.^{3,4}

Lastly, Foëx points out that our research is not comparable to the Tuskegee "bad blood" study. We have made no attempt to draw a comparison, and a literature search of PubMed showed many other medicoscientific papers with "bad blood" in the title, covering a range of topics.

Anthony Kessel *honorary lecturer in public health medicine*
Epidemiology Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT
anthony.kessel@lshtm.ac.uk

- 1 Rachels J. *The elements of moral philosophy*. New York: McGraw-Hill, 1993.
- 2 Kopelman LM. Informed consent and anonymous tissue samples: the case of HIV seroprevalence studies. *J Med Philos* 1994;19:525-52.
- 3 Clouser KD, Gert B. A critique of principlism. *J Med Philos* 1990;15:219-36.
- 4 Davis R. The principlism debate: a critical overview. *J Med Philos* 1995;20:85-105.

Post-traumatic stress disorder in doctors involved in the Omagh bombing

EDITOR—Firth-Cozens et al draw naive conclusions from their questionnaire survey of doctors involved in the Omagh bombing, which supposedly showed that 25% of them had post-traumatic stress disorder.¹ In my clinical experience post-traumatic stress disorder models so lack precision in distinguishing between subjective distress and objective disorder that the vast majority of "cases" represent a pseudocondition.² The tendency of trauma models to transform the social into the biomedical is particularly exposed in highly public events like this: if ordinary human responses—empathic distress, a sense of horror and outrage, and so on—fit a biomedical paradigm for a considerable proportion of workers who are merely doing their duty, there is something wrong with the paradigm. The core clinical question is surely whether any of these doctors are impaired in their capacity to function.

Noting that only half of those involved professionally in the atrocity had sought help, the authors state that those who delay are at risk of developing more severe and entrenched symptoms. There is simply no basis for this assertion. After a literature survey Wessely et al concluded that there was

no evidence that psychological debriefing was useful in preventing post-traumatic stress disorder after traumatic incidents, and other authors concur.^{3,4} It is interesting that debriefing is often popular with those who go through it, perhaps because it is better understood as an exercise in personnel management than as prophylactic mental health work.

This question of inappropriate medicalisation and imputation of a sick role has a considerable societal resonance at present. The workplace is being represented as a setting that can generate post-traumatic stress disorder: paramedics attending road accidents, police constables attending disasters or atrocities, and even employees caught up in what they would once have described as a simple dispute with management are all seeking compensation for post-traumatic stress disorder, or for not being offered counselling. A soldier is suing the Ministry of Defence for exposing him to the horrors of war when he was a peacekeeper in Bosnia. The recent reformulation of post-traumatic stress disorder in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association widened the criteria for traumatic stressors, making it still more useful to an expansive trauma industry. Although we recognise that the medicalisation of life has been a Western cultural trend gathering pace in the past century, some professional stocktaking is surely overdue.

Derek Summerfield *principal psychiatrist*
Medical Foundation for the Care of Victims of Torture, London NW5 3EJ

- 1 Firth-Cozens J, Midgley S, Burges C. Questionnaire survey of post-traumatic stress disorder in doctors involved in the Omagh bombing. *BMJ* 1999;319:1609. (18-25 December.)
- 2 Summerfield D. A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Soc Sci Med* 1999;48:1449-62.
- 3 Wessely S, Rose S, Bisson J. A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress. In: *Cochrane Review. Cochrane Library*. Issue 2. Oxford: Update Software, 1998.
- 4 Raphael B, Meldrum L, McFarlane A. Does debriefing after psychological trauma work? *BMJ* 1995;310:1479-80.

Accidents at home are no more likely in deprived areas

EDITOR—Lyons and colleagues highlighted the need for more evidence on the socio-demographic profile of non-fatal injury.¹ In 1995 I reviewed routine health data in Dumfries and Galloway, Scotland, and identified deprived and affluent populations in the region (residents of the 15% of census enumeration districts with the highest and lowest deprivation scores respectively).² The review analysed 27 894 hospital episodes in 1992. I compared deprived and affluent groups using standardised admission ratios, the standardised admission ratio for the whole of Dumfries and Galloway being 100. A higher rate of admissions for home accidents (all ages) was found among residents of deprived enumeration districts. However, this did not reach statistical

significance—the standardised admission ratio in the deprived group was 129 (95% confidence interval 105.6 to 152.9) compared with 96 (86.2 to 105.9) in the affluent group.

Instead of using electoral wards (as used by Lyons et al) it may be preferable to use enumeration districts to subgroup populations in such studies because enumeration districts are more likely to contain more homogeneous populations in regard to socioeconomic deprivation, thus making the ecological fallacy of transferring relationships observed in a population to individuals in that population less likely.³

Gerry Waldron *consultant in public health medicine*
Northern Health and Social Services Board,
Ballymena BT42 1QB
gerry.waldron@nhssb.n-hs.uk

- 1 Lyons RA, Delahunty AM, Heaven M, McCabe M, Allen H, Nash P. Incidence of childhood fractures in affluent and deprived areas: population based study. *BMJ* 2000;320:149. (15 January.)
- 2 Waldron G. *Health and deprivation in Dumfries and Galloway—a review of routine health data*. Dumfries: Dumfries and Galloway Health Board, 1995.
- 3 Skrabaneck P, McCormick J. *Follies and fallacies in medicine*. Glasgow: Tarragon, 1989.

Incidence of hospital admission does not equal incidence of disease

Conclusions drawn from data are incorrect

EDITOR—We are concerned about Gaist and colleagues' methods and feel that the conclusions they draw from their data are incorrect.¹

The diagnosis of subarachnoid haemorrhage was validated in a sample from only one county. Is Funen County representative of Denmark, and how was it selected? Hospitals with 10 or fewer registered patients in the study period were excluded. Why was it appropriate to exclude the smaller hospitals when they may be a source of patients with particularly low predictive value for a registered diagnosis of subarachnoid haemorrhage?

The cohort of first degree relatives was overwhelmingly made up of children, and they were the only group in table 2 for whom the incidence rate ratios were significantly different from 1. The main problem with the study is one that plagues much of the literature on subarachnoid haemorrhage—it was hospital based. The strongest predictor of survival in subarachnoid haemorrhage is age. This is just as true when considering who will survive to reach medical attention. In a recent population based review of 824 cases of subarachnoid haemorrhage in Devon and Cornwall, the proportion of patients dying outside hospital was 7% and 17% for those of less than and more than 45 years of age respectively. It is therefore not surprising that, as has been shown in this study, a group aged 33 years is more likely to be admitted to hospital after a subarachnoid haemorrhage than a group aged 53. In addition, these first

degree relatives were generally patients who had a parent who had experienced subarachnoid haemorrhage in the past few years. They and their own families would therefore be highly aware of this condition and its serious consequences and be more likely than the general population to refer themselves for investigation and to press for referral to a specialist centre.

This study suggests that first degree relatives are more likely than the general population to be admitted to hospital following a subarachnoid haemorrhage. If the differences in age and awareness between index cases and relatives are considered, however, it would seem to go beyond the data to conclude that first degree relatives are more likely to have a subarachnoid haemorrhage.

Louis H Pobereskin *consultant neurosurgeon*
louis.pobereskin@phnt.swest.nhs.uk

J Robert Sneyd *consultant anaesthetist*
Derriford Hospital, Plymouth PL6 8DH

- 1 Gaist D, Væth M, Tsiropoulos I, Christensen K, Corder E, Olsen J, et al. Risk of subarachnoid haemorrhage in first degree relatives of patients with subarachnoid haemorrhage: follow up study based on national registries in Denmark. *BMJ* 2000;320:141-5. (15 January.)

Authors' reply

EDITOR—Pobereskin and Sneyd question the choice of a single county for validation of the registered diagnosis of subarachnoid haemorrhage and query our exclusion from the validation study of cases admitted to hospitals with fewer than 10 cases. We validated the diagnosis in two groups of patients: a random sample of patients discharged from hospitals in Funen County (n=210) and all identified cases in the family (n=37) from hospitals in Denmark. The random sample was restricted to Funen County for logistical reasons—ease of access to medical records. The county is geographically well delineated and the inhabitants (450 000) are a representative 10% sample of the Danish population.^{1 2} The incidence of subarachnoid haemorrhage in Funen County is similar to that of Denmark. Funen County does not differ in any major way from other counties in Denmark in its access to health care and referral of patients with subarachnoid haemorrhage. It is served by several small hospitals and one university hospital (1400 beds), the only hospital in the county with a neurology and neurosurgery unit. When we were sampling the cases for validation it was practical to exclude patients from two smaller hospitals in Funen, which had discharged fewer than 10 patients each during the 18 year follow up. This excluded 15 patients or 0.2% of all patients with subarachnoid haemorrhage identified in Funen County during the period. We believe that this exclusion had no methodological consequences.

Pobereskin and Sneyd found that younger patients with subarachnoid haemorrhage in Devon and Cornwall are more likely to be admitted to hospital. They ask whether this is a problem for our cohort of first degree relatives comprising mainly young adults. Even if such an age effect were present in our material it would not have

influenced our results since we controlled for age. The incidence of subarachnoid haemorrhage in the cohort of relatives was compared with the incidence of subarachnoid haemorrhage in the general population of Danes from the same age group.

The final issue raised by Pobereskin and Sneyd is that of awareness. First degree relatives of patients with subarachnoid haemorrhage may be more likely to seek help since they are familiar with the symptoms, a potential limitation that we also pointed out. However, according to an evaluation of the medical records by an experienced neurologist who was blinded with regard to family relationships, familial cases did not differ from non-familial cases in severity or presenting symptoms.

David Gaist *postdoctoral fellow*
dgaist@health.sdu.dk

Kaare Christensen *research professor*
Epidemiology, Institute of Public Health, Odense University, University of Southern Denmark, DK 5000 Odense C, Denmark

Michael Væth *professor*
Department of Biostatistics, University of Aarhus, DK 8000 Aarhus, Denmark

Ioannis Tsiropoulos *consultant neurologist*
Department of Neurology, Odense University Hospital, Odense, Denmark

Jørn Olsen *professor*
Danish Epidemiology Science Centre, University of Aarhus, DK 8000 Aarhus, Denmark

Henrik Toft Sørensen *associate professor*
Department of Clinical Epidemiology of Aarhus and Aalborg University Hospitals at the Institute of Epidemiology and Social Medicine, University of Aarhus, DK 8000 Aarhus, Denmark

- 1 Green A. *The county of Funen 1972-74. A comparative demographic study of the county of Funen and Denmark as a whole with regard to use of data from Funen county for epidemiological studies*. Odense: Department of Genetics, Odense University, 1978. (Report in Danish.)
- 2 Gaist D. Use and overuse of sumatriptan. Pharmacoeconomic studies based on prescription register and interview data. *Cephalalgia* 1999;19:735-61.

Social networks are important in preventing dependency in old age

EDITOR—The apparently obvious, but also often forgotten, importance of social networks and social support were missing from the editorial by Metz on preventing dependency in old age.¹ Metz comments that exercise improves physical fitness, muscle size, strength, and balance and reduces the risk of falls. However, in addition to increasing cardiopulmonary fitness, physical activity may confer survival benefits through psychosocial pathways.² Social and other activities requiring less physical exertion may therefore complement exercise and be alternative interventions for improving the health of older people.

Social networks and social support are increasingly recognised as important determinants of health in elderly people. Biological mechanisms have been postulated, and several long term longitudinal studies support an association with health.³ Consequently, innovations in technology have the

great potential to reduce dependency both directly and indirectly by affecting social relationships.

Little research has been done on the determinants of social networks and social support in elderly people. These should be now be more specifically investigated because increased understanding may benefit the health of older people living in the community at less cost than some of the more high tech innovations. We particularly need to know the key determinants of social networks and social support and whether any of them can be modified. Interventions arising from this type of research are likely to link the services provided by the health service with those provided by social services. Fortunately, the reorganisation of primary care allows primary care groups and primary care trusts to provide a forum where interventions between health and social services can be put into practice.

Helen Stoddart *lecturer*
helen.stoddart@bristol.ac.uk

Debbie Sharp *professor*
Division of Primary Health Care, University of Bristol, Canynge Hall, Bristol BS8 2PR

Ian Harvey *professor*
School of Health Policy and Practice, University of East Anglia, Norwich NR4 7TJ

- 1 Metz D. Innovation to prevent dependency in old age. *BMJ* 2000;320:460-1. (19 February.)
- 2 Glass TA, de Leon CM, Marottoli RA, Berkman LF. Population based study of social and productive activities as predictors of survival among elderly Americans. *BMJ* 1999;319:478-83.
- 3 Berkman C, Syme LS. Social networks, host resistance and mortality: a nine year follow-up of Alameda County residents. *Am J Epidemiol* 1979;109:189-204.

Statins for stroke should be considered in biologically fit people over 75

EDITOR—Oliver suggests that statin use after a stroke should be restricted to patients under 75.¹ Although trials showing the benefits of these drugs have excluded patients above this age, evidence suggests that these data may reasonably be extrapolated to older patients.

Firstly, the relative benefits of statins in the 4S (Scandinavian simvastatin survival study), CARE (cholesterol and recurrent events), and LIPID (long term intervention with pravastatin in ischaemic disease) trials were similar above and below the age of 65.² An inflection point at the age of 75 therefore seems unlikely, so benefits may extend beyond this age limit. Indeed, the absolute benefits may be greater in older patients because of their higher risk of vascular events.

Secondly, the ratio of total to high density lipoprotein cholesterol continues to be predictive of coronary heart disease in octogenarians.³ Statins may stabilise vulnerable atheromatous plaques. This therapeutic effect may not reflect the relation between serum cholesterol concentration and atherogenesis and might reduce risk regardless of age.⁴ In the 4S trial significant reductions in end points occurred after only

18 months of treatment.⁵ As life expectancy at 80 is about eight years, many older patients will live long enough to benefit from statins.

Finally, evidence suggests that older and younger patients benefit to a similar degree from cardiovascular interventions ranging from thrombolysis to treatment of hypertension. Indeed, we are not aware of any cardiovascular intervention that has been proved effective in younger but ineffective in older patients.

Clinicians weigh up the risks and benefits of treatment, then play the best odds for their patients. In the absence of definitive evidence, these data suggest that restricting statins to those under 75 may be failing to play the best odds for some older patients. The RESPECT (risk evaluation and stroke prevention in the elderly cerivastatin trial), PROSPER (prospective study of pravastatin in elderly at risk), and FAME (fluvastatin assessment of morbidity and mortality in the elderly) trials are currently evaluating statins in patients up to the age 85.

In the interim, older patients should be assessed with an emphasis more on biological than chronological age, an approach reflected in recently produced national guidelines from the intercollegiate stroke working party. Treatment should at least be considered in biologically fit older patients with a life expectancy of over two years. A dogmatic interpretation of current trial data may not serve older patients well, a group in whom the majority of cardiovascular events will occur.

J Kelly *specialist registrar*
A Rudd *consultant*

Stroke Unit, St Thomas's Hospital, London SE1 7EH

- 1 Oliver MF. Cholesterol and strokes. *BMJ* 2000;320:459-60. (19 February.)
- 2 Carlsson CM, Carnes M, McBride PE, Stein JH. Managing dyslipidemia in older adults. *J Am Geriatr Soc* 1999;47:1458-65.
- 3 Kannel WB, Wilson PF, Larson MG, Evans JC. Coronary risk factors and coronary prevention in octogenarians. In: Wenger NK, ed. *Cardiovascular disease in the octogenarian and beyond*. London: Martin Dunitz, 1999: 141-63.
- 4 Miettinen TA, Pyörälä K, Olsson AG, Musliner TA, Cook TJ, Faergeman O, et al. Cholesterol lowering therapy in women and elderly patients with myocardial infarction or angina pectoris. *Circulation* 1997;96: 4211-8.
- 5 Scandinavian Simvastatin Survival Study Group. Randomised trial of cholesterol lowering in 4444 patients with coronary heart disease: the Scandinavian Simvastatin Survival Study (4S). *Lancet* 1994; 344:1383-9.

Language, fairness, and the MRCGP examination

Political correctness going too far

EDITOR—Surely the article by Roberts et al article is political correctness again going too far.¹ If the candidate is consistently compromised in terms of understanding an examiner, he or she will be more of a liability to employ in a situation where good communication is the essence of good general practice.

After all, it is the doctor's duty to familiarise himself or herself with the language of the community in which he or she has chosen to practise, not the duty of

the majority to pander to their doctor's linguistic shortcomings.

George Boulos *trainer, Oxford region*,
Tilehurst Surgery, Tylers Place, Tilehurst, Reading,
Berks RG30 6BW
gboulos@netcomuk.co.uk

- 1 Roberts C, Sarangi S, Southgate L, Wakeford R, Wass V. Oral examinations—equal opportunities, ethnicity, and fairness in the MRCGP. *BMJ* 2000;320:370-4. (5 February.)

What is important is who will make a good doctor

EDITOR—Boulos is misguided when he says that Roberts et al's excellent article¹ on the nuances of language is "political correctness gone too far." He is also being disingenuous when he says that it is "the doctor's duty to familiarise himself or herself with the language of the community in which he or she has chosen to practise."

I presume he means that all overseas doctors should have an excellent command of English. That's a viewpoint to which he is entitled. I wish he would campaign for applying it consistently. If he did and if the Royal College of General Practitioners applied this criterion then doctors would have to learn (and the MRCGP examination would have to test knowledge of) the nuances not of the English spoken by Oxbridge graduates but of English and its many variants, and arguably in some areas even of other languages. After all, these are the communities in which real doctors practise medicine. This could be carried further. How many British graduates working in non-English speaking countries really know the language of their patients?

Roberts et al's paper makes the excellent point that language and discourse get in the way of the examination doing its intended job—which is to judge whether a candidate will make a good doctor. The young doctor in A J Cronin's book *The Citadel* had a similar problem when he wanted, as a doctor working in the Welsh valleys, to take the membership examination. At that time it included a compulsory paper in Latin. It was totally unrelated to the practice of medicine and served no higher purpose other than to keep young upstarts out of "the club." We now recognise this to be a form of indirect discrimination.

For a general practice trainer to dismiss Roberts et al's well argued message as empty political correctness and no more is deeply depressing.

Jammi N Rao *deputy director of public health*
Sandwell Health Authority, West Bromwich
B70 9LD
jammi.rao@bharat.demon.co.uk

- 1 Roberts C, Sarangi S, Southgate L, Wakeford R, Wass V. Oral examinations—equal opportunities, ethnicity, and fairness in the MRCGP. *BMJ* 2000;320:370-4. (5 February.)

bmj.com

Rapid responses

Correspondence submitted electronically is available on our website